

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Patties
Township Washington
Village _____
City _____ (NO. _____)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 1664 File No. 6273
Primary Registration District No. 4297 Registered No. 3
5884 St. _____ Ward _____

FULL NAME John H Poinssignon

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE Widower
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Dec 1/Nov 1
(Month) (Day) (Year)

AGE 87 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmers
(b) General nature of industry, business, or establishment in which employed (or employer) 1000

BIRTHPLACE (City or town, State or foreign country) France

PARENTS NAME OF FATHER Donk / know
BIRTHPLACE OF FATHER (City or town, State or foreign country) France
MAIDEN NAME OF MOTHER Donk / know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Donk / know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) W C Clobaugh

(ADDRESS) Green Ridge
Filed Feb 15 1912 W C Clobaugh REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 28 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 27, 1912, to Jan 28, 1912, that I last saw him alive on Jan 28, 1912, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:
Pneumonia
100
(Duration) _____ yrs. _____ mos. 4 ds.

Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W C Clobaugh M. D.
Feb 12 1912 (Address) Green Ridge

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Adelia Mo DATE OF BURIAL Jan 29 1912
UNDERTAKER Adelia Mo ADDRESS Adelia Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



PLACE OF DEATH

County Pettis
 Township Washington
 OR
 Village _____
 OR
 City _____ (NO. _____ St. _____ Ward _____)

REGISTRARS SHALL NOT RE-
 CEIVE A FEE FOR CERTIFICATES
 UNTIL THEY ARE COMPLETED AS
 PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Registration District No. 664 File No. 6273
 Primary Registration District No. 5884 Registered No. 3

(If death occurred in a
 hospital or institution,
 give its NAME instead
 of street and number)

FULL NAME

John N. Poinssignon

PERSONAL AND STATISTICAL PARTICULARS

SEX m. COLOR OR RACE w. SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED w.
 (Write the word)
 DATE OF BIRTH Don't know.
 (Month) (Day) (Year)
 AGE 87 yrs. ____ mos. ____ ds. If LESS than
 1 day, ____ hrs. ____ min.

OCCUPATION
 (a) Trade, profession, or
 particular kind of work Farmer

(b) General nature of industry,
 business, or establishment in
 which employed (or employer) _____

BIRTHPLACE
 (City or town, State
 or foreign country) France

PARENTS
 NAME OF FATHER Don't know
 BIRTHPLACE OF FATHER France
 (City or town, State or foreign country)
 MAIDEN NAME OF MOTHER _____
 BIRTHPLACE OF MOTHER _____
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. W. Clabaugh
 (ADDRESS) Green Ridge Mo

File March 10 1912
 REGISTRAR O. W. Clabaugh

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. 28, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
Jan. 24, 1912, to Jan. 28, 1912,
 that I last saw him alive on " ", 1912,
 and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ____ yrs. ____ mos. 4 ds.

Contributory
 (SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.
 (Signed) O. W. Clabaugh M. D.
North 1912 (Address) Green Ridge

*State the Disease Causing Death, or, in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR
 RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted
 if not at place of death?

Former or
 usual residence _____

PLACE OF BURIAL OR REMOVAL

Sedalia Mo.

UNDERTAKER

Sedalia Mnd. Co.

DATE OF BURIAL

Jan. 29, 1912

ADDRESS

Sedalia Mo.

Original file, date FEB, 19____

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)